STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155791	B. WING		03/29/2012
NAME OF I	PROVIDER OR SUPPLIE	ER.		ADDRESS, CITY, STATE, ZIP CODE	
		MDLIC		ADOWVIEW DR	
	IDGE HEALTH CA	IMPUS	PERU,	IN 46970	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
F0000	REGULATORT OF	R ESC IDENTIFY TING INFORMATION)	TAG		DATE
This visit was for the Investigation of		F0000			
	Complaint #IN0	_			
	Complaint #IN00105485 Substantiated.				
	Federal/state deficiencies related to the				
	allegations are o	eited at F225, F226, F323,			
	and F502.				
	Survey dates: March 28-29, 2012				
	Facility number: 012565				
	Provider numbe	er: 155791			
	Aim number: 2	01021970			
	Survey team:				
	Honey Kuhn, R	N			
	Census bed type	<del>2</del> :			
	SNF: 23				
	SNF/NF: 5				
	Total: 28				
	Census payor ty	pe:			
	Medicare: 14				
	Medicaid: 5				
	Other: 9				
	Total: 28				
	Sample: 5				
	Tri 1 0 '	:			
		ies reflect stated findings			
	cited in accorda	nce with 410 IAC 16.2.			
	-		•		•

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155791	: <b>A.</b>	.2) MULTIPLE CO. BUILDING WING	00	COMPI 03/29	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 269 MEADOWVIEW DR PERU, IN 46970					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PERCEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE		
	Quality review completed 4/3/12 Cathy Emswiller RN							

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Event ID: PENK11

Facility ID: 012565

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDIC	00	COMPLETED
		155791	A. BUILDING B. WING		03/29/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	₹			
BLAIR RI	DGE HEALTH CAN	MPUS	269 MEADOWVIEW DR PERU, IN 46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(	iii), (c)(2) - (4)			
SS=D	INVESTIGATE/F				
	ALLEGATIONS/				
	-	not employ individuals who			
		d guilty of abusing,			
		istreating residents by a court			
		nad a finding entered into the			
	State nurse aide registry concerning abuse, neglect, mistreatment of residents or				
	•				
		n of their property; and report			
		t has of actions by a court of mployee, which would			
	-	· ·			
	indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide				
	registry or licensing authorities.				
	region y or neeric	mig dationities.			
	The facility must	ensure that all alleged			
	violations involvi	ing mistreatment, neglect, or			
	abuse, including	injuries of unknown source			
	and misappropri	ation of resident property are			
	reported immedi	ately to the administrator of			
		o other officials in accordance			
		rough established			
		uding to the State survey and			
	certification age	ncy).			
	The feetite manes	lhava avidanaa that all			
	•	have evidence that all			
	-	s are thoroughly investigated,			
	•	nt further potential abuse gation is in progress.			
	write the investig	gation is in progress.			
	The results of al	I investigations must be			
		administrator or his			
		esentative and to other			
	-	dance with State law			
		State survey and certification			
	` .	working days of the incident,			
	and if the allege	d violation is verified			
	appropriate corre	ective action must be taken.			
	Based on record	review and interviews,	F0225	1. Corrective Action	04/28/2012
		d to follow the facility's		accomplished for those reside	nts
	and facility failed	2 to 10110 w the facility 5		found to have been affected b	у

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SU	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155791	B. WIN			03/29/2	2012
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ADOWVIEW DR		
BLAIR R	IDGE HEALTH CAN	MPUS			IN 46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		edure in regards to			the alleged deficient		
	reporting to ISD	H (Indiana State			practice: Resident F fall was submitted to the State Board of	· .	
	Department Health) and thoroughly				Health for review on	"	
	investigating an unwitnessed fall which				3-28-12. Waffle mattress was		
	resulted in a fracture for 1 of 5 dependent				removed from bed immediately	y	
	residents who incurred a fall in a sample of 5. (Resident "F")  Finding includes:  The record of Resident "F" was reviewed				after fall. Resident F continued		
					have abductor pillow in place i		
					discountinuation on 4-2-12. Be		
					pillow to be between knees x 2 weeks after abductor pillow	<u> </u>	
					discountinued. Circulatory che	cks	
					started on 3-30-12. Resident	lono	
					F had x-ray done on 3-25-12 of	on	
	on 03/29/12 at 12:20 p.m. Resident "F"				hip to establish		
	was admitted to	the facility on 03/12/12			alignment. Resident F was sei		
	with diagnoses in	ncluding, but not limited			ER on 3-26-12 due to swelling		
	to, history of fall	ls, (R) (right) hip fracture,			hand to have cast adjusted an evaluated.Resident F was	u	
	(R) wrist fracture	e, CRF (Chronic Renal			discharge from the facility on		
		laucoma, and dementia.			4-23-12.2. Indentification of ot	her	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•			residents having potential to b	e	
	During the initia	l tour, between 10:00			affected by the same alleged		
	_	.m. on 03/28/12,			practice will include:Resident's risk for falls will be reviewed a		
		the Clinical Care			individualized care plans will b		
	1 1	CC-RN), Resident "F" was			updated to include preventions		
	`	urring a fall at home			and interventions by		
		· ·			4-28-12.Nursing staff will be		
		) hip & (R) wrist fracture			educated by 4-28-12 to review		
		nort-term skilled resident.			safety procedures, fall prevent	tion,	
		s identified as not			reporting of allege abuse, accidents and incidents to Sta	te	
	interviewable an	d requiring assist of 2			and Federal entities.3. Measur		
	staff for transfer	s and toileting. The			put in place and systemic	-	
	CCC-RN indicat	ed Resident "F" had an			changes made to ensure the		
	unwitnessed fall since admission to the				allege practice does not		
	facility.				reoccur:On a ongoing basis th	e	
					DHS/designees will review all incidents and accidents 5 days	_	
	A confidential in	nterview, during the			per week for appropriate	´	
		d Resident "F" had fallen			interventions. Fall Circumstar	ice	
	survey, murcated	i resident i nad lanen				-	

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155791	B. WIN			03/29/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADOWVIEW DR	
BLAIR R	IDGE HEALTH CAN	MPUS			IN 46970	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	and fractured a f	inger after admission.			forms will be assessed for	
	The interviewee	indicated Resident "F"			completion and root cause	
	had relayed she had to go to the bathroom				analysis. DHS or ED will be notified for any incident that	
	1	get up by herself. The			occurs on a weekend and	
	_	cated Resident "F" "could			requires reporting to a state or	
		not find her call light." The interviewee			federal agency.4. Corrective	
	indicated the family was not in the facility				actions will be monitored to	
	on 03/25/12 unti	3			ensure the alleged practice do	
	on 03/23/12 unti	i after the fall.			not reoccur:On a ongoing bas	
					the DHS/designees will review new admissions and	/
	Review of all records dated before 03/25/12 indicated Resident "F" had a (R) hip fracture and (R) wrist fracture, with				re-admissions for appropriate	
					interventions to the residents	care
					plan and appropriate follow up	
	no mention of a	finger fracture.			days per week.QA process wi	ll be
					utlized for additional	
	Review of the pr	re admission x-rays and			recommendations if indicated	
	the post fall x-ra	·			monthly.Compliance Date:	
	the post ran x-ra	ys marcated.			4-28-12	
	"03/07/2012 6:5	55 p.m.: Findings:				
	Comminuted in	_				
		shaft of radiusUlnar				
		s also appreciatedSoft				
	tissues: Unremai	rkable"				
		.=				
		27 p.m.: Findings:There				
		verse comminuted				
	fracture of the ba	ase of the proximal				
	phalanx of the fi	fth fingerThere is soft				
	tissue swelling o	over the dorsum of the				
	hand"					
	Review of Physi	cian's orders, dated				
	03/19/12, indicate	ted:				
	"PT (Physical	Therapy) gait training				
	` •	bearing as tolerated) (R)				

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Event ID: PENK11

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	(X2) MULTIPLE CO A. BUILDING B. WING	00	COI	TE SURVEY MPLETED 729/2012	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 269 MEADOWVIEW DR PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	placed and secur patient following	nity) ductor pillow: a device ed between the legs of a g hip surgery to prevent @ (at) ALL times while					
	"03/24/12 1000 (removed from (FdifficultyCast	es's notes indicated: (10:00 a.m.) Staples (2) hip s (without) D&I (dry & intact) on (3). Fingers pink, warm,					
	(9:30 a.m.) Pt (p beside bed leanin closet door. Had BM (bowel mov	ndicated: "03/25/12 0930 patient) found on floor ng on (R) side resting on been incont (incontinent) ement) & (and) urine. time & place"					
	(Orthopedic Surg swollen & (and) tight around fing	(10:30 a.m.) Called geon) re: (R) hand cast appears to be to (sic) gers. (Orthopedic today. Suggest we send al (evaluation)"					
	Assessment and 03/25/12, indicat "Activity at time self"	Fall Circumstance Intervention", initiated ted: of fall: Transferring Inspection: Other: found					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791		LDING	NSTRUCTION  00	(X3) DATE COMPI 03/29	LETED
	PROVIDER OR SUPPLIER		p. wii.	STREET A	ADOWVIEW DR N 46970	•	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	"waffle mattress' family"	on bed placed by					
	cognitive status, was in place, wh checked for toile	ation did not address if the abductor pillow en Resident "F" was last ting/incontinence prior to cation of the call light.					
	(Orthopedic Surg swollen & (and) tight around fing	oday. Suggest we send					
	interviewed on 0 DNS indicated the facility for respit	tor Nursing Services) was 3/29/12 at 1:30 p.m. The ne resident was in the e care only and the finger 11ght to have occurred n.					
	Review of the far Procedure: 11/20 AND INCIDENT GUIDELINES",	10, titled, "ACCIDENT Γ REPORTING					
	incidents and allo involving resider	sure all accidents, egation of abuse nts, visitors, or employees and reported to the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155791	B. WIN	G		03/29/2012	
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
D. A.D. D.		451.10			ADOWVIEW DR		
BLAIR R	IDGE HEALTH CAN	MPUS		PERU, I	N 46970		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE	
	facility administr	ration."					
	IID 1 5	D					
		Reporting of incident,					
	accidents and abuse to state and federal						
	~	in compliance in					
		agency guidelines."					
		trative staff shall					
	-	estigation, by completion					
	of the "Interdisciplinary Team: section of						
	the Circumstance and Reassessment form						
	and/or State Agency form as required."						
	D : 0.1 11.4	DUCE AND MEGLECT					
		ABUSE AND NEGLECT					
	PROCEDURAL						
	11/2010", indica	-					
	"Purpose: Trilog	= <del>-</del>					
	· ·	e to ensure the prevention					
		suspected or alleged					
	resident abuse ar	nd neglect."					
	1 1						
	"Procedure:g. I						
	_	ember, resident, visitor or					
		may report known or					
	suspected abuse,	<del>-</del>					
	misappropriation	to local or state					
	agencies.						
		l reporting to applicable					
	state agencies						
	-	ort of the investigation					
		ng resident response					
		, final conclusion and					
	actions taken to prevent reoccurrence,						
		d to the applicable State					
	Agencies within	five days."					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM 03/2	TE SURVEY MPLETED 29/2012		
NAME OF I	PROVIDER OR SUPPLIEF	?		ADDRESS, CITY, STATE, ZII EADOWVIEW DR	P CODE			
BLAIR R	IDGE HEALTH CAN	MPUS	PERU, IN 46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
IAU		relates to Complaint	IAG			DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155791	A. BUILDING	00	COMPLETED 03/29/2012
		133791	B. WING		03/29/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
BLAIR R	IDGE HEALTH CAI	MPUS		EADOWVIEW DR IN 46970	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0226 SS=D	ETC POLICIES The facility must written policies a mistreatment, no residents and m property.  Based on record the facility failed Policy and Proce reporting to ISD Department Heat investigating an resulted in a fract residents who in of 5. (Resident "Finding includes The record of Residents who in of 5. (Resident "Finding includes The record of Residents who in of 5. (Resident "Finding includes The record of Residents who in of 5. (Resident "Finding includes The record of Residents who in of 5. (Resident "Finding includes The record of Residents who in of 5. (Resident "Finding includes The record of Residents who in of 5. (Resident "Finding includes The record of Residents and 10:30 at a decompanied by Coordinator (CC identified as incresulting in a (Residents and Residents a	t develop and implement and procedures that prohibit eglect, and abuse of isappropriation of resident review and interviews, d to follow the facility's edure in regards to effect (Indiana State alth) and thoroughly unwitnessed fall which eture for 1 of 5 dependent incurred a fall in a sample (F")  S:  esident "F" was reviewed 2:20 p.m. Resident "F" the facility on 03/12/12 including, but not limited als, (R) (right) hip fracture, re, CRF (Chronic Renal laucoma, and dementia.  If tour, between 10:00 in.m. on 03/28/12, it the Clinical Care (CC-RN), Resident "F" was urring a fall at home in the contracture of the contracture in the con	F0226	1. Corrective Actions accomplished for those reside found to have been affected by the alleged deficient practice: Resident F fall was submitted to the State Board of Health for review on 3-28-12. Waffle mattress was removed from bed immediated after fall. Resident F continued have abductor pillow in place discontinuation on 4-2-12. Bed pillow to be between knees x weeks after abductor pillow discountinued. Circulatory chestarted on 3-30-12. Resident F had x-ray done on 3-25-12 on to establish alignment. Reside was sent to ER on 3-26-12 du swelling of hand to have cast adjusted and evaluated. Resid F was discharged from the facton 4-23-12.2. Identification of other residents having the potential to be affected by the same allege practice will include: Resident's at risk for fawill be reviewed and individualized care plans will be updated to include preventions and interventions by 4-28-12. Nursing staff will be educated by 4-28-12 to reviewed.	y to until 2 cks hip hit Fee to ent cility
	and as being a sl	hort-term skilled resident.		safety procedures, fall prevent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	a. Building 00			COMPLETED	
		155791	- 1			03/29/2	2012	
			B. WIN		ADDRESS CITY STATE ZID CODE			
NAME OF 1	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE			
	IDOE LIEALTH OA	MDUO			ADOWVIEW DR			
BLAIR R	IDGE HEALTH CA	IMPUS		PERU,	IN 46970			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Resident "F" wa	as identified as not			reporting of allege abuse,			
	interviewable a	nd requiring assist of 2			accidents and incidents to Sta			
		rs and toileting. The			and Federal entities.3. Measu	res		
		ated Resident "F" had an			put in place and systemic			
					changes made to ensure the allege practice does not			
		l since admission to the			reoccur:On a ongoing basis th	۵		
	facility.				DHS/designees will review all			
					incidents and accidents 5 days	s		
	A confidential i	nterview, during the			per week for appropriate			
	survey, indicate	ed Resident "F" had fallen			interventions. Fall Circumstar	nce		
	1	finger after admission.			forms will be assessed for			
		e indicated Resident "F"			completion and root cause			
	had relayed she had to go to the bathroom				analysis. DHS or ED will be			
	I -	_			notified for any incident that occurs on a weekend and			
	1	o get up by herself. The			requires reporting to a state or			
		icated Resident "F" "could			federal agency.4. Corrective			
	not find her call	light." The interviewee			actions will be monitored to			
	indicated the far	mily was not in the facility			ensure the alleged practice do	es		
	on 03/25/12 unt	il after the fall.			not reoccur:On a ongoing bas			
					the DHS/designees will review			
	Review of all re	ecords dated before			new admissions for appropriat			
		ted Resident "F" had a (R)			interventions to the residents			
		` /			plan and appropriate follow up			
	_	(R) wrist fracture, with			days per week. QA process w be utilized for additional	"		
	no mention of a	finger fracture.			recommendations if indicated			
					monthly.5. Compliance Date:			
	Review of the p	ore admission x-rays and			4-28-12.			
	the post fall x-ra	ays indicated:						
	"03/07/2012 6.	55 p.m.: Findings:						
		impacted Colles'						
		shaft of radiusUlnar						
styloid fracture is also appreciatedSoft								
	tissues: Unrema	ırkable"						
	"03/26/2012 2:	27 p.m.: Findings:There						
		sverse comminuted						

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Facility ID: 012565

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791	(X2) MUL A. BUILD B. WING		NSTRUCTION  00	(X3) DATE : COMPL 03/29/	ETED
	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ADOWVIEW DR N 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	phalanx of the fit	se of the proximal fth fingerThere is soft ver the dorsum of the					
	03/19/12, indicat "PT (Physical Towns WBAT (weight of the LE (lower extrem ABD pillow (about placed and securpatient following)	Therapy) gait training pearing as tolerated) (R)					
	"03/24/12 1000 ( removed from (R difficultyCast	s's notes indicated: 10:00 a.m.) Staples hip s (without)  D&I (dry & intact) on Fingers pink, warm,					
	(9:30 a.m.) Pt (p beside bed leaning closet door. Had BM (bowel move	dicated: "03/25/12 0930 attient) found on floor ag on (R) side resting on been incont (incontinent) ement) & (and) urine. time & place"					
	(Orthopedic Surg	10:30 a.m.) Called geon) re: (R) hand cast appears to be to (sic) ers. (Orthopedic					

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Event ID: PENK11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155791	B. WIN	IG		03/29/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		ADLIC			ADOWVIEW DR		
	IDGE HEALTH CAN				IN 46970		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	l `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		today. Suggest we send	+	0			5.112
	,	al (evaluation)"					
	ner to Ele for eve	ii (Cvaraation)					
	Review of the "F	Fall Circumstance					
		Intervention", initiated					
	03/25/12, indicat						
	· · · · · · · · · · · · · · · · · · ·	of fall: Transferring					
	self"	Č					
	"Environmental	Inspection: Other: found					
	"waffle mattress"	on bed placed by					
	family"	_ <del>-</del>					
	"Root cause: far	nily placed waffle					
	mattress on bed	"					
	•	ation did not address					
	cognitive status,	if the abductor pillow					
		en Resident "F" was last					
		ting/incontinence prior to					
	the fall, or the lo	cation of the call light.					
		(10:30 a.m.) Called					
	`	geon) re: (R) hand					
	` ′	cast appears to be to (sic)					
	~ ~	ers. (Orthopedic					
		today. Suggest we send					
	her to ER for eva	al (evaluation)"					
	TI DIG (D)						
		tor Nursing Services) was					
		3/29/12 at 1:30 p.m. The					
		ne resident was in the					
		te care only and the finger					
		ight to have occurred					
	prior to admissio	on.					

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
155791		B. WING	G		03/29/	2012	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ADOWVIEW DR		
BLAIR R	IDGE HEALTH CAN	MPUS		PERU, I	IN 46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Review of the fa	•					
		010, titled, "ACCIDENT					
	AND INCIDEN						
	GUIDELINES",	indicate:					
	,	11					
		sure all accidents,					
	incidents and all	•					
		nts, visitors, or employees					
		and reported to the					
	facility administr	ration."					
	"Dwo oo duwo 5	Reporting of incident,					
		use to state and federal					
	_	in compliance in					
		agency guidelines."					
		trative staff shall					
		estigation, by completion					
		plinary Team: section of					
		e and Reassessment form					
	and/or State Age	ncy form as required."					
	Daviess after "A	ADDICE AND NECLECT					
		ABUSE AND NEGLECT					
	PROCEDURAL						
	11/2010", indica	, , , , , , , , , , , , , , , , , , ,					
	"Purpose: Trilog						
		e to ensure the prevention					
		suspected or alleged					
	resident abuse ar	nd neglect."					
	"Dragadyras - 1	Donartina					
	"Procedure:g. I	-					
	_	ember, resident, visitor or					
		may report known or					
	suspected abuse,	_					
	misappropriation	to local or state					

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Event ID: PENK11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155791	A. BUILDING B. WING	00 	COMPLETED 03/29/2012
NAME OF PROVIDER OR SUPPLIER  BLAIR RIDGE HEALTH CAMPUS		269 ME	ADDRESS, CITY, STATE, ZIP CODE EADOWVIEW DR IN 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	state agencies iv. A written repoutcome, including and/or condition, actions taken to paid will be submitted Agencies within	I reporting to applicable ort of the investigation ng resident response final conclusion and prevent reoccurrence, I to the applicable State five days."  relates to Complaint			

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Event ID: PENK11

Facility ID: 012565

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		DING	COMPLETED COMPLETED		ETED		
		155791	B. WIN			03/29/2012		
NAME OF F	DROVADED OD GLIDDI IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	KOVIDER OR SUPPLIER			269 ME	ADOWVIEW DR			
BLAIR RIDGE HEALTH CAMPUS				,	IN 46970			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
	`				CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TΕ		
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0323 SS=G	483.25(h) FREE OF ACCID HAZARDS/SUPPI The facility must environment rem hazards as is poreceives adequa assistance devic Based on record the facility failed resident who incresident reviewed 5. Findings include  The record of Re on 03/29/12 at 12 was admitted to to with diagnoses in to, history of fall (R) wrist fracture Failure), gout, gl  During the initial a.m. and 10:30 a accompanied by Coordinator (CC identified as incuresulting in a (R) and as being a sh Resident "F" was interviewable and	DENT ERVISION/DEVICES ensure that the resident nains as free of accident ssible; and each resident te supervision and es to prevent accidents. review and interviews, I to ensure the safety of 1 urred an unwitnessed fall ctured finger for 1 d for falls in a sample of  : esident "F" was reviewed 2:20 p.m. Resident "F" the facility on 03/12/12 ncluding, but not limited s, (R) (right) hip fracture, e, CRF (Chronic Renal aucoma, and dementia.  I tour, between 10:00	F03		1. Corrective Actions accomplished for those reside found to have been affected by the alleged deficient practice: Resident F fall was submitted to the State Board of Health for review on 3-28-12. Waffle mattress was removed from bed immediately after fall. Resident F continued have abductor pillow in place of discontinuation on 4-2-12. Bed pillow to be between knees x 2 weeks after abductor pillow discontinued. Circulatory check started on 3-30-12. Resident F had x-ray done on 3-25-12 on to establish alignment. Resider was sent to ER on 3-26-12 due swelling of hand to have cast adjusted and evaluated. Reside F was discharged on 4-23-12. Identification of other residents having the potential to be affect by the same allege practice wi include: Resident's at risk for fawill be reviewed and individualized care plans will be updated to include preventions and interventions by 4-28-12. Nursing staff will be educated by 4-28-12 on call lig placement. An audit tool will be developed to check 5 residents.	f  / to until  s  hip at F  et to ent c. deted  II ulls  e	04/28/2012	
	resulting in a (R)	hip & (R) wrist fracture			•			
	_							
	_							
	_							
	During the initial	Ltour between 10.00						
	i anaroj, godi, gr	aucoma, and acmentia.			_	ent		
	Failure), gout, gl	aucoma, and dementia.						
	` ′							
	1 '	, ( ) ( 0 ) 1						
	to, history of fall	s, (R) (right) hip fracture,						
	with diagnoses in	ncluding, but not limited						
		•			1	S		
		-			•			
	on 03/29/12 at 12	2:20 p.m. Resident "F"			1 3	2		
						•		
	The record of Re	sident "F" was reviewed						
					• · · · · · · · · · · · · · · · · · · ·	ıntil		
	Findings include	:						
	Findings include	:			1			
	E: 1: : 1 1				1			
						,		
	J.				3-28-12.Waffle mattress was			
		•						
	resident reviewed	d for falls in a sample of				Ť		
	_	_			1 -	£		
					_			
	resident who inc	urred an unwitnessed fall				/		
	the facility failed	to ensure the safety of 1			· ·			
		·	1 103	43		ate	04/28/2012	
		•	E03	23	1 Corrective Actions		04/28/2012	
	-							
	1							
33-6								
		SENT						
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	Ē	COMPLETION	
							` ′	
(VA) ID	CID O A DV C	TATEMENT OF DEFICIENCIES		ID	T		(37.5)	
BLAIR R	IDGE HEALTH CAN	MPUS		PERU,	IN 46970			
				269 ME	ADOWVIEW DR			
NAME OF F	PROVIDER OR SUPPLIER							
				ADDRESS CITY STATE ZIP CODE				
		155791	B WIN	G		03/29/	2012	
AND PLAN	OF CORRECTION	A. BUILDING		DING	00			
AND DLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			l i				
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)			JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  O	COMPLETED
155791 B. WING	03/29/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	Е
NAME OF PROVIDER OR SUPPLIER  269 MEADOWVIEW DR	
BLAIR RIDGE HEALTH CAMPUS PERU, IN 46970	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL)  TAG REGULATORY OR USC IDENTIFYING INFORMATION)  TAG DEFICIENCY)	OPRIATE
TAG REGULATOR ON ESC IDENTIFICATION	DATE
residente e menth y 2 may	nths
unwitnessed fair since admission to the then 5 residents a month;	
facility. month.sQA process will be	e
utilized for additional	
A confidential interview, during the recommendations if indications if indications if indications if indications if indications in indication in indications in indication	I
survey, indicated Resident "F" had fallen monthly.3. Measures put i and systemic changes ma	•
and fractured a finger after admission.	
The interview indicated Resident "F" had not reoccur:Upon admission	
relayed she had to go to the bathroom and Community Service	
attempted to get up by herself. The Representative (CSR) or	
interview indicated Resident "F" "could designee will review with t	the
not find her call light." The interview resident, family and/or responsible party the important	ortance
indicated the family was not in the facility of family and staff commu	I
on 03/25/12 until after the fall.	
added and/or removed inv	•
Review of all records dated before the resident's plan of care	
Review of all records dated before provide examples of intervolution and provide examples of intervolution a	
inp fracture and (K) what fracture, with	
no mention of a finger fracture.	
resident, familyand/or resp	•
Review of Physician's orders, dated party current interventions of place, new interventions and place, new interventions are placed.	
objective the research involving the research involving the research	I
plan of care.On a ongoing	I
WBAT (weight bearing as tolerated) (R) the DHS/designees will re	
LE (lower extremity) incidents and accident rep	I
ABD pillow (abductor pillow: a device and Fall Circumstance Fo completion, root cause an	I
placed and secured between the legs of a and appropriate intervention	7
patient following hip surgery to prevent add to the resident care pl	
hip dislocation) @ (at) ALL times while ensure appropriate follow-	-up 5
in bed" days per week. QA proces	ss will
be utilized for additional recommendations if indica	ated
Review of the "Fall Circumstance monthly.4. Corrective action	
Assessment and Intervention", initiated be monitored to ensure the	I
03/25/12, indicated: alleged practice does not	

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIII	LDING	00	COMPLETE	D	
		155791	B. WIN			03/29/201	12
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ADOWVIEW DR		
BLAIR RIDGE HEALTH CAMPUS				IN 46970			
BLAIN N	IDGE HEALTH CAN	MF 03		FERU,	110 40970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE CC	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"Activity at time	of fall: Transferring			reoccur:On a ongoing basis th	е	
	self"				DHS/designees will review all		
	   "Environmental"	Inspection: Other: found			incidents and accident reports	_	
		' on bed placed by			and Fall Circumstance Forms		
		on ocu piaccu by			completion, root cause analysi and appropriate interventions		
	family"				and appropriate interventions a		
		nily placed waffle			ensure appropriate follow-up 5		
	mattress on bed	"			days per week. Residents with		
					falls will be discussed at the		
	Review of Nurse	s's notes indicated:			weekly CAR meeting x 4 week	s	
	"03/24/12 1000 (	10:00 a.m.) Staples			post fall. QA process will be		
	removed from (R	·			utilized for additional		
	,				recommendations if indicated		
	· ·	D&I (dry & intact) on			monthly.5. Compliance Date:		
		). Fingers pink, warm,			4-28-12.		
	freely movable."						
	The next entry in	idicated: "03/25/12 0930					
	(9:30 a.m.) Pt (r	patient) found on floor					
	, ,	ng on (R) side resting on					
		been incont (incontinent)					
		` '					
	,	ement) & (and) urine.					
	Very confused to	time & place"					
	"03/26/12 1030 (	10:30 a.m.) Called					
	(Orthopedic Sur	geon) re: (R) hand					
		cast appears to be to (sic)					
	tight around fing						
		` •					
	- '	oday. Suggest we send					
	her to ER for eva	ıl (evaluatıon)"					
	Review of the pr	e admission x-rays and					
	the post fall x-ray	ys indicated:					
	"03/07/2012 6·5	5 p.m.: Findings:					
	Comminuted in						
	Commuuted II	npacted Colles					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155791		LDING	NSTRUCTION  00	(X3) DATE COMPL 03/29/	ETED
NAME OF PROVIDER OR SUPPLIER BLAIR RIDGE HEALTH CAMPUS		p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE ADOWVIEW DR N 46970	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
		haft of radiusUlnar s also appreciatedSoft kable"					
	is an acute transver fracture of the bar phalanx of the fit tissue swelling of hand  IMPRESSION: A intra-articular fraction proximal phalant.  The DNS (Direct interviewed on the different proximal phalant.)  The DNS (Direct interviewed on the different phalant.)  The DNS (Direct interviewed on the differen	7 p.m.: Findings:There verse comminuted use of the proximal fth fingerThere is soft ver the dorsum of the  Acute comminuted ucture of the base of the acute of the base of the acute of the fifth finger"  tor Nursing Services) was 3/29/12 at 1:30 p.m. The me resident was in the resident was in the regards to the post fall indicated the fall was ent "F" sliding out of bed uttress was placed on the acute the waffle mattress until after the fall. The din regards to the necked for toileting right and if the staff would the waffle mattress was ne. The DNS was also ident's abductor pillow on the resident was found					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155791	A. BUI B. WIN	LDING	00	03/29/2012
NAME OF E	PROVIDER OR SUPPLIEF		b. WIN		ADDRESS, CITY, STATE, ZIP CODE	
	IDGE HEALTH CAN				ADOWVIEW DR IN 46970	
(X4) ID		TATEMENT OF DEFICIENCIES		ID I	10070	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		e DNS indicated the				
	_	I not address the resident				
	_	or toileting or the				
		7. The DNS indicated the				
	,	nt Administration Record)  f the abductor pillow was				
	in place.	i the abductor pillow was				
	in place.					
	Review of the T.	AR, dated 03/2012, for				
		licated: "03/19/12 Cont				
	(continue) abduc	ction pillow while in bed				
	x 2 weeks, then	D/C (discontinue)				
	04/02/12". The	TAR addressed each shift				
	with a signature:	: 6:00 a.m2:00 p.m.;				
	_	p.m.; 10:00 p.m6:00				
	•	did not identify when the				
	abduction pillow	was put on or removed.				
	Review of the "N	Nursing Admission				
	Assessment & D	Oata Collection" dated				
	03/12/12, indicar	ted:				
1	"Mobility and A	DL's (Activities of Daily				
	Living): Transfe	rs/Wheelchairs: Assist of				
	2. Assistive Dev	ice: Abductor pillow"				
	1	DL Plan of Care:				
		sist of x 2; Use fracture				
		protocolEncourage use				
	of call light for a	assistance"				
l	"Elimination:I	ncontinence product use:				
	Briefs;Usual V	oiding Pattern: Upon				
	rising, After mea	als, Before bed;Urge				
	Incontinence: Y	(yes); Wakes at night:				

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155791			LDING	NSTRUCTION  00	(X3) DATE S COMPL 03/29/	ETED	
	PROVIDER OR SUPPLIER		p. w.i.v	STREET A	DDRESS, CITY, STATE, ZIP CODE ADOWVIEW DR N 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	"Elimination Pla rising, before/aft Use toilet/bedpar	n of Care:Toilet upon er meals, before bedtime; n,; Use Night time brief ing at night; Provide					
	Requires Assista Y;Resident is u forgets to use: Y "Safety Plan of C for transfers and needed;Ensure reach;Instruct i light."	nce to transfer: Y; nce to ambulate: nnable use call lights:" Care: Provide assistance					
	3.1-45(a)(2)						

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Event ID: PENK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155791		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/29/2012	
		155791	B. WING		03/29/2012
NAME OF PROVIDER OR SUPPLIER  BLAIR RIDGE HEALTH CAMPUS			269 MI	ADDRESS, CITY, STATE, ZIP CODE EADOWVIEW DR , IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0502 SS=D	SVC-QUALITY/ The facility musservices to mee The facility is retimeliness of the Based on record facility failed to for laboratory be for 1 of 1 reside blood work in a "E")  Finding include  The closed recoreviewed on 03/Resident "E" was on 03/05/12 with not limited to, CObstructive Pulic (Congestive Heafailure, and a hiddhydration. The home on 03/23/  Review of the Pedated 03/2012, is "CMP (Complet Lipid Profile, Count) 3/6/12"	t provide or obtain laboratory t the needs of its residents. sponsible for the quality and e services.  I review and interview, the ensure a physician's order lood work was completed ints who had ordered is sample of 5. (Resident  s:  rd of Resident "E" was 29/12 at 9:15 a.m. is admitted to the facility the diagnoses including, but COPD (Chronic monary Disease), CHF art Failure), pre-renal estory of severe the resident was discharged 12.  thysician's Order Sheet,	F0502	1. Corrective Actions accomplished for those reside found to have been affected be the alleged deficient practice: Resident #E has been discharged from the facility. Resident had order at the of admission to have a CBC, BMP and Lipd Profile obtained with no specific date attached order to obtain specimen. Chawere reviewed on 3-29-12 to assure March labs had been completed in timely fashion. Clawas obtained on 3-9-12. Residents having the potential be affected by the same allegorative will include: Residents with lab orders will be reviewed Monday thru Friday in the Clin Meeting and orders will be plain the Lab Tracking Book, including new admission labs. Nursing staff will be inserviced on Lab Tracking for and completion and follow through orders by 4-28-12.3. Measures put in place and systemic changes made to ensure the allege practice does not reoccur: The DHS and Clin Team will review all new admissions, re-admissions and	y n ime d to rts  3C ults nd to e d cial ced  rm u of

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	OF CORRECTION  IDENTIFICATION NUMBER:  155791	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 03/29/2012
	PROVIDER OR SUPPLIER IDGE HEALTH CAMPUS	269 ME	ADDRESS, CITY, STATE, ZIP CODE EADOWVIEW DR IN 46970	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the DNS (Director Nursing Services), on 03/29/12 at 10:45 a.m., indicated the labs were not drawn. The DNS indicated being unaware the tests had been ordered.  Review of a Policy & Procedure, provided by the Regional Nurse on 03/29/12 at 2:30 p.m., titled, "Lab Tracking Guidelines: 11/22/08", indicated: "PURPOSE: To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner  2. The nursing staff or person designated by the Executive Director of Director of Health Services shall monitor the "Tracking Log" to ensure tests have been completed per the physician order."  This Federal tag relates to Complaint #IN00105485.  3.1-49(a)		previous days orders for completion and follow up.4. Corrective actions will be monitored to ensure the alleginative does not reoccur:On ongoing basis, the DHS /designee will review new admissions, re-admissions an previous days orders for completion and follow up 5 day week and as part of the ongoing QA process.QA process will but utilized for additional recommendations if indicated monthly.5. Compliance Date: 4-28-12.	a d nys a ng

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